



HIGHLIGHTS

December 2009

CONGRESSIONAL TESTIMONY

Counselor, AIG for Audits & Evaluations Testify on Acquisition Deficiencies in VA

Counselor to the Inspector General, Maureen Regan, and Assistant Inspector General for Audits and Evaluations, Belinda Finn, testified before the U.S. House of Representatives' Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations, on acquisition deficiencies in VA. Ms. Regan told the Subcommittee that Office of Inspector General (OIG) audits, reviews, and investigations have identified systemic issues that caused or contributed to procurement failures, overpayments, and misuse of funds. These issues include poor acquisition planning, poorly written contracts, inadequate competition, no price reasonableness determinations, and poor contract administration.

OIG REPORTS

De-Obligation of Funds for Undelivered Orders Could Save \$276 Million

OIG audited the Veterans Health Administration's (VHA) "undelivered orders," which are goods and services ordered that have not been received. The audit determined that internal controls to identify invalid undelivered orders need improvement. As of December 2008, VHA had about 83,000 undelivered orders valued at approximately \$6.5 billion. Approximately \$276 million could be put to better use in accordance with appropriations law if invalid orders are identified in a timely manner and funds de-obligated to be used for other purposes. OIG recommended VHA establish procedures to ensure proper follow-up and reconciliation of undelivered orders and ensure that all undelivered orders have end dates to allow for follow-up and reconciliation. [\[Click for Report.\]](#)

Patient Record System Outage Attributed to Substandard Maintenance

OIG reviewed allegations surrounding a Veterans Health Information Systems and Technology Architecture (VistA) outage within the VA North Texas Healthcare System (HCS). The outage was caused by hard disk failures in conjunction with outdated storage system firmware. The review revealed that the Office of Information and Technology (OI&T) failed to perform a firmware upgrade that had been directed by the vendor 2 years prior. Additionally, a report from the vendor identified significant issues relating to the aging infrastructure with critical recommendations that OI&T has not addressed. Although no patient safety incidents were reported as a result of the VistA outage, but the after action report and staff interviews showed the incident seriously

affected patient care. OIG also confirmed the allegation that the Office of Risk Management and Incident Response does not manage, track, or trend risks related to these system outages, but only reports incidents to higher echelons within OI&T. OIG made five recommendations to address these issues and OI&T concurred. [\[Click for Report.\]](#)

VHA Needs to Improve Compliance with Pharmacy Regulations and Guidance

OIG completed an evaluation of select pharmacy processes related to the management of controlled substances (CS) at 43 VHA medical facilities. Overall, pharmacies complied with CS guidelines, security, and reporting requirements; however, OIG recommended that management reinforce compliance with VHA regulations and United States Pharmacopeia guidelines. OIG also recommended that management encourage facilities to provide guidance for clinical review of polypharmacy in high-risk populations. [\[Click for Report.\]](#)

Quality, Workload, and Training Improvements Needed at San Juan, Anchorage VA Regional Offices

OIG conducted an onsite inspection at the San Juan, PR, VA Regional Office (VARO) to review disability compensation claims processing and Veteran Service Center operations. OIG determined management needs to improve the quality of formal benefits decisions. At the end of March 2009, the VARO had the lowest national average for accuracy associated with these decisions, at 60 percent. Personnel responsible for processing claims identified as diabetes, post-traumatic stress disorder (PTSD), and traumatic brain injury (TBI) require additional oversight and training. Management also needs to improve controls over correcting errors identified by Systematic Technical Accuracy Reviews (STAR), completing Systematic Analysis of Operations (SAO) accurately and timely, safeguarding Veterans' personally identifiable information (PII), safeguarding VARO date stamps, handling claims-related mail, responding to electronic inquiries, and processing fiduciary activities. [\[Click for Report.\]](#)

OIG conducted a similar onsite inspection at the Anchorage, AK, VARO. OIG determined the VARO needs to address oversight of operational activities, improve insufficient network capacity to support business processes, and provide training to staff. Management acknowledged its workload was not under adequate control. In addition, an internal claims brokering process was in use; however, the process lacks criteria for what type of claim can be brokered. Personnel responsible for processing claims identified as Haas, PTSD, diabetes, and TBI require additional oversight and training. Management also needs to improve controls over tracking Veterans' claims in Control of Veterans Records System, establishing correct dates of claims, correcting errors identified by STAR, completing SAOs accurately and timely, safeguarding VARO date stamps and Veterans' PII, handling Veterans' claims-related mail, and responding to congressional and other electronic inquiries. [\[Click for Report.\]](#)

Reviews Conducted of Eight Community Based Outpatient Clinics

OIG reviewed eight Community Based Outpatient Clinics (CBOCs) throughout Veterans Integrated Service Networks 7, 12, and 23, visiting Macon and Albany, GA; Rockford and Galesburg, IL; Sioux City and Waterloo, IA; Beaver Dam, WI; and Aberdeen, SD.

The review covered five areas: quality of care measures, credentialing and privileging, environment of care and emergency management, patient satisfaction, and CBOC contracts. OIG noted several opportunities for improvement and made a total of 17 recommendations. [\[Click for Report.\]](#)

Delay in Cancer Diagnosis Substantiated Against Milwaukee VA Medical Center

OIG reviewed the validity of allegations regarding a delayed cancer diagnosis, treatment, and disclosure of an adverse event to a patient treated at the Clement J. Zablocki VA Medical Center (VAMC) in Milwaukee, WI. OIG substantiated that there was a delay in cancer diagnosis and treatment, a radiologist failed to identify a lung nodule, the primary physician failed to follow up on the lung nodule, and a second radiologist failed to notify the primary physician. OIG also substantiated that staff initially failed to disclose the adverse event to the patient. OIG recommended that managers conduct a formal peer review and root cause analysis on all activities involving care of the identified patient, staff adhere to VHA and local incident reporting and adverse event disclosure policies and procedures, and managers consult Regional Counsel regarding disclosure to the family and explanation of rights. [\[Click for Report.\]](#)

OIG Examines Allegations Surrounding Patient's Death at North Chicago VAMC

OIG examined allegations regarding the care provided to a patient who died within 24 hours of admission to the North Chicago, IL, VAMC. The complainant suggested that a medical trainee may have been inadequately supervised. OIG found the quality of care reviews conducted by the VAMC to be thorough. Although the review found deficiencies in the quality of care provided for this patient, the evidence did not demonstrate a connection with the patient's death. OIG recommended that managers evaluate this case with Regional Counsel for possible disclosure to the patient's family and that staff comply with the VAMC's policy for rapid intervention in patients with deteriorating clinical conditions. [\[Click for Report.\]](#)

Quality of Care Allegations Examined at the Salt Lake City HCS

OIG performed a review of the Salt Lake City, UT, HCS to determine the validity of the following allegations: (1) lack of collaboration, inappropriate care, and deaths; (2) unwarranted amputations; and (3) inappropriate management of vein patients. OIG substantiated poor collaboration between Interventional Radiology and Vascular Surgery for two of the four patients identified, but concluded that this did not directly contribute to the fatal outcomes. OIG concluded that the HCS took appropriate actions to review quality of care and make improvements, which included conducting institutional disclosures in two of the four cases. However, OIG recommended that one case be referred to Regional Counsel to determine whether the HCS has an obligation to report the providers to the National Practitioners Data Base. Since management had already addressed this issue at the time of OIG's review, OIG considers this recommendation closed. OIG did not substantiate the occurrence of unwarranted amputations or inappropriate management of vein patients. [\[Click for Report.\]](#)

Allegations Against Central Arkansas Veterans HCS Not Substantiated

OIG did not substantiate allegations that a patient at the Central Arkansas Veterans HCS in Little Rock, AR, was inadequately diagnosed and treated for severe abdominal pain or that he was placed in a locked room where no one checked on him for over 6 hours. OIG was unable to substantiate or refute that someone told the patient's wife he had been discharged but they did not know where he was located. To reinforce effective communication with families, the Director issued a memorandum while OIG was onsite. OIG made no recommendations. [\[Click for Report.\]](#)

Allegations Against CBOCs in Smyrna and Rome, Georgia, Unfounded

OIG reviewed the merits of allegations that a Veteran was denied access to care at a Rome, GA, CBOC and whether that same Veteran was not diagnosed or treated for lip cancer at the Smyrna, GA, CBOC or for decreased renal function at the Rome, GA, CBOC. OIG did not substantiate that the Veteran was denied care or that the lip cancer or decreased renal function were not diagnosed or treated. OIG made no recommendations. [\[Click for Report.\]](#)

Patient Allegations Against Amarillo, Texas, VA HCS Unfounded

OIG did not substantiate any allegations made against the Amarillo, TX, VA HCS. Specifically, a patient and his wife alleged he was entitled to have VA reimburse his air ambulance co-pay, that the emergency department (ED) and inpatient admission wait was excessive, that his PTSD diagnosis was not considered when assigning a roommate, and that an anti-anxiety injection left him incoherent for 3 days. They also alleged that his diabetes was untreated, he did not see a physician for 24 hours, and the ED and medical unit were filthy. Because the allegations were not substantiated, OIG made no recommendations. [\[Click for Report.\]](#)

Allegations Not Substantiated Against Harrisonburg, Virginia, Contracted CBOC

OIG conducted an inspection in response to allegations that the Martinsburg, WV, VAMC, through its contracted CBOC in Harrisonburg, VA, provided incomplete physicals and omitted digital rectal examinations (DREs) to a patient over the course of 3 years. OIG did not substantiate that the patient's physicals were not thorough and that DREs were not addressed. OIG made no recommendations. [\[Click for Report.\]](#)

CRIMINAL INVESTIGATIONS

Chief Executive Officer Sentenced for Making False Statements

The Chief Executive Officer (CEO) of a biotechnology company was sentenced to 8 months' incarceration, 3 years' probation, a \$77,228 fine, and ordered to pay restitution of \$22,772 after pleading guilty to making false statements. The CEO also pled guilty on behalf of his company to making false statements. The company was subsequently sentenced to a \$20,000 fine. A multi-agency investigation revealed that from 2001 to 2002, the CEO authorized the alteration of data related to the purity of chemical compounds manufactured by the company and sold to VA and other Federal agencies.

Veteran Arrested for Compensation Fraud

A Veteran was arrested for making false statements and wire fraud. The Veteran was rated with a 100 percent service-connected disability and was also collecting special monthly compensation for the complete loss of the use of his lower extremities. An OIG and U.S. Secret Service investigation determined that the defendant continuously submitted false medical claims, testimony, and requests to VA for over 20 years stating that he could not ambulate without assistance, when in fact the Veteran had full mobility. The loss to VA is \$526,539.

Veteran Sentenced for Making Threats to VA

A Veteran was sentenced to 3 years' incarceration and 3 years' probation after pleading guilty to making threats against VA and its employees. The Veteran's sentence was enhanced due to prior threats he made against VA. In October 2008, the defendant sent a letter to the Baton Rouge, LA, VAMC outpatient clinic stating that he would carry out specific threats if his demands were not met within 90 days.

Veteran's Daughter Pleads Guilty to Theft of VA Funds

The daughter of a Veteran, who was also the wife of a State judge, pled guilty to theft of Government funds. An OIG investigation determined that between 2001 and 2008, the defendant fraudulently received VA pension benefits, on behalf of her father, based on false financial statements she made to VA. An OIG investigation revealed that the defendant and her three siblings created an investment company for the purpose of hiding their parents' financial assets. This action then made the parents eligible for various Government benefit programs, to include VA. The investment company's partnership agreement and company itself were created by the defendant's husband while he was still in office. The defendant, who was also her father's fiduciary, subsequently stole most of the fraudulently obtained VA pension benefits. The loss to VA is \$110,848.

Former Augusta, Georgia, VAMC Employee Sentenced for Workers' Compensation Fraud

A former Augusta, GA, VAMC nurse's aide was sentenced to 6 months' home confinement, 5 years' probation, 100 hours' community service, and ordered to pay restitution of \$8,190. An OIG and Department of Labor OIG investigation determined that the defendant made false statements in order to fraudulently obtain Federal workers' compensation benefits. The investigation revealed that the defendant worked as a home improvement contractor while collecting workers' compensation.

Defendants Sentenced for Theft of VA Benefits from Deceased Beneficiary

The son of a VA Dependency and Indemnity Compensation beneficiary was sentenced to 4 months' incarceration, credited as time served, and ordered to pay \$34,892 in restitution. A co-defendant was sentenced to 2 years' probation and ordered to pay \$5,207 in restitution. Both defendants previously pled guilty to theft of Government funds after an OIG investigation determined that both defendants stole, forged, and negotiated VA benefit checks issued after the beneficiary's death in 1994.

Palo Alto, California, Nursing Instructor Sentenced for Diversion of VA Drugs

A community college clinical nursing instructor teaching at the Palo Alto, CA, VAMC was sentenced to 3 years' probation after pleading guilty to possession of a controlled substance. An OIG investigation determined that the nurse diverted Hydromorphone on at least four different occasions after she fraudulently obtained access to a VAMC Accudose machine.

Defendant Pleads Guilty to Health Care Fraud

A former account manager with a company that provided home health care services to patients covered by various health care programs, including Medicaid and VA, pled guilty to a criminal information charging him with knowingly and willfully defrauding a health care program. An OIG, Health and Human Services OIG, and Federal Bureau of Investigation (FBI) investigation determined that the defendant altered employee documents to make them appear compliant with State licensing regulations during audits of the company's operations.

Former Bay Pines, Florida, Employee Indicted for Child Pornography Possession

A former Bay Pines, FL, VAMC employee was indicted for possession of child pornography after an OIG and FBI investigation revealed that the defendant used his VAMC network folder to store images of child pornography.

Veteran Indicted for Fraud Involving VA Guaranteed Loans

A Veteran was indicted for mortgage fraud, bank fraud, and identity theft relating to an extensive \$1.6 million mortgage fraud scheme that began in 2002. An OIG, U.S. Secret Service, and FBI investigation determined that the defendant supplied VA with fraudulent social security numbers (SSNs) in order to qualify for VA guaranteed loans. The defendant was discharged from the U.S. Army under "other than honorable" conditions and would not have qualified for VA loans using his correct SSN. The loss to VA is approximately \$56,000.

Former Syracuse VAMC Employee Sentenced for Bank Fraud

A former Syracuse, NY, VAMC employee was sentenced to 3 years' probation and ordered to pay restitution of \$7,781 after pleading guilty to bank fraud. The defendant used her position at the VAMC to gain access to a Veteran's bank card and personal identification number and subsequently stole funds from the Veteran's account after his death.

Brother of Veteran Pleads Guilty to Identity Theft

The brother of a Veteran was arrested and subsequently pled guilty to a criminal information charging him with identity theft. The defendant fraudulently obtained a VA identification card, two credit cards, driver's licenses from two different states, a social security card, and a birth certificate using his brother's identity. An OIG, U.S. Secret Service, and local police investigation revealed that the defendant also assumed his brother's identity in order to fraudulently receive approximately \$13,275 in VA medical care for 10 years.

Veteran Indicted for VA Pension Fraud

A Veteran was indicted and subsequently arrested for theft of Government property. An OIG investigation revealed that for 4 years the defendant fraudulently received VA pension benefits by failing to accurately report to VA his employment disability pension and social security earnings. The loss to VA is \$44,994.

Veteran Indicted for Stolen Valor

A Veteran was arrested after being indicted for theft of Government funds. An OIG investigation determined that the defendant submitted a fraudulent Purple Heart certificate to VA in order to support his claim for VA compensation benefits. The loss to VA is approximately \$24,000.

(original signed by:)

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